Step-By-Step Physical Therapy, PC

In order to serve you most effectively, please provide us with the following information. All information will be kept strictly confidential

Patient Name:_____DOB_____AGE:_____

Billing Address:_____State:_____Zip:_____

Phone (home): ( )_____ (work)( )_____ (cell) ( )_____

Email Address:_____ Will you accept texts: **Y / N**

Marital Status: Married Single Widowed Other Work Status: Employed Retired Student Other

Occupation:_____ Are you currently working: **Y / N**

Nature of Condition: Gradually Onset Injury Employment Motor Vehicle Accident Unknown Other

Date of Onset:_____ Date of Surgery if Applicable:_____

Briefly describe the problem for which you are being seen in this office:_____

_____

How did your problem occur:_____

What activities increase pain: _____

What reduces pain:_____

What position is most comfortable:

On a scale of 0 to 10 (10 being most severe), please circle the number that best describes your current pain level:

0 1 2 3 4 5 6 7 8 9 10

Current Medications: Please list or attach

_____

_____

Have you had any of the following: Xrays CT SCANS MRI INJECTIONS OTHER:_____

If so, When and Where were test performed: _____

Have you been Hospitalized or had Surgery for **THIS** problem**: Y / N If yes, When? _____**

Date of Surgery:_____ Type of surgery:_____ # of times_____

Do you have any Hardware (screws, plates, metal implants) ?_____

Do you have any Allergies**:** _____

Do you smoke or use Tobacco? **Y / N** if so, How much?_____

Please circle if any of the following conditions apply to you: Cancer Arthritis Gout Pregnancy Diabetes Epilepsy
Stomach Problems Bowel or Bladder Problems Heart Pacemaker Unexpected weight (circle) Loss / Gain Osteoporosis
Other:_____

Have you had any Physical Therapy in this Current Year? Y / N If so, When?_____

Have you recently or Currently receiving Home Care Services? Y / N If so, When? _____

BILLING:
Insurance: Please Fill in ALL Insurance Information: (even if claim is Comp or NF)

PRIMARY INSURANCE

Company Name:_____

Subscriber:_____

Policy #_____

Group#_____

SECONDARY INSURANCE

Company Name:_____

Subscriber:_____

Policy#_____

Group#_____

WORKERS COMP:

Company Name:_____

Address: _____

Adjuster:_____

Phone#_____

Case#_____

Date of Injury: _____

Soc Sec#_____

NO FAULT INS:

Company Name:_____

Address:_____

Adjuster:_____

Phone# _____

Case#_____

Date of Accident:_____

Soc Sec#_____

(Most Comp and No Fault Ins will ask for your social security # when we call for information)

FinancialResponsibility: (Please Initial Acknowledgement_____)

You are repsonsible to provide us with the most up to date insurance card at the first appointment and upon any changes. All copays and co-insurances will be due at each appointment. If you are working on a deductible, you will be responsible to pay $80 for the eval and $50 each follow up. If the insurance charges you more, we will let you know the difference owed and if they charge less, we will refund the difference.

Privacy Practice: (Please Initial Acknowledgement_____)

By Law we are required to provide you with our Notice of Privacy Practice (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you may obtain access to this information.

Payment: (Please Initial Acknowledgement_____)

I hearby authorize paymentdirected to Step By Step Physical Therapy for all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, wether paid by insurance, and for all services rendered on my behalf or my dependent. I authorize this office to release any information to secure payment of benefits. I authorize this signature on all insurance submissions.

I certify that all information I have provided is true and accurate.

I hereby authorize payment directed to Step-by-Step PT for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependent.
I authorize this office to release any information to secure payment of benefits. I authorize this signature on all insurance submissions.

Signature of Responsible Party:_____ Date:_____